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ABSTRACT

A recent development in the field of personality assessment has been increasing interest in the use of the Millon Clinical Multiaxial Inventory (MCMI) in clinical settings. The MCMI Scales 1 (Schizoid), 2 (Avoidant), 3 (Dependent), and 8 (Passive-Aggressive) appear to be a possible measure of initial stress in certain psychiatric inpatients. To examine the prevalence of the 1-2-3-8 codetype profile pattern among psychiatric inpatients, the MCMI profiles for 131 psychiatric inpatients were subjected to analysis. Thirty-five of the 131 subjects had profiles in which scales 1,2,3, and 8 were the four highest scales. Analysis of the diagnoses and clinical records of these patients suggest that this profile reflects an affect/mood disturbance with prominent depressive features and suicidal ideation/attempt prior to admission. This investigation serves mainly as a stimulus for research questions that should be addressed in order to increase the range of clinical applications of the MCMI and the body of empirical literature that can support the utility of this assessment device. (NB)

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Clinical Applications of the MCMI:

The 1-2-3-8 Codetype

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Running head: THE 1-2-3-8 MCMI CODETYPE

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Abstract

MCMI profiles were obtained for 118 consecutive acute psychiatric inpatient admissions. A preponderance of this diagnostically mixed inpatient sample obtained a 1-2-3-8 "codetype elevation". These MCMI elevations purportedly reflect a schizoid, avoidant, dependent, and passive-aggressive blend of personality traits. Analyses of the DSM III diagnoses and clinical records of these patients revealed that the 1-2-3-8 profile identified: (a) "initial distress", (b) an affective disorder-depression, and (c) suicidal thought. Implications for recognizing the importance of this high point codetype elevation and for continuing research are discussed.

Clinical Applications of the MCMI:

The 1-2-3-8 Codetype

A recent development in the field of personality assessment has been increasing interest in the use of the Millon Clinical Multiaxial Inventory (MCMI) in clinical settings. Because the instrument is based on a comprehensive theory of psychopahtology (Millon, 1969, 1981) and has withstood rigorous psychometric testing (Millon, 1983), it is viewed as a very promising and innovative assessment device (McCabe, 1984). Another potential strength of the MCMI appears to be the correspondence of its scales with the DSM-III (American Psychiatric Association, 1980), though this point has been questioned by Widiger, Williams, Spitzer, and Frances (1985, 1986).

Perhaps the most significant criticism that could be made of the MCMI is the clear lack of available research and clinical literature that exists (McCabe, 1984). In fact, little work has appeared in the literature on the MCMI outside Millon's group of investigators. Only in the past two years can one see any significant step toward expanding the clinical applications of this potentially valuable tool.

One area of recent interest has been the use of the MCMI on inpatient psychiatric populations. The MMPI has long been used for clinical assessment with objective self-report measures.

However, more recently clinicians have begun to employ the MCMI because of its brevity, relative to the MMPI, and a close correspondence with the DSM-III, specifically the Axis II personality disorders, which the MMPI does not achieve. Piersma (1986b) found the basic personality scales of the MCMI to be generally more stable among inpatients than the clinical symptom scales. More specifically, Piersma (1986a) found meaningful changes in MCMI profiles as a result of inpatient treatment. It was found that scores on Scales 1 (Schizoid), 2 (Avoidant), 3 (Dependent), and 8 (Passive-Aggressive) decreased between admission and discharge while there were noticeable elevations on Scales 4 (Histrionic), 5 (Narcissistic), 6 (Antisocial), and 7 (Compulsive). These changes might be expected in that "patients would experience themselves as less withdrawn, introverted, dependent, and complaining at discharge, while they would feel more outgoing, confident, assertive, and in control of their lives at discharge" (p. 498).

These findings are important in light of the clinical assessment work that is being done by the authors with psychiatric inpatients. More specifically, we have noticed that a seemingly disproportionate number of inpatients obtain clinically significant elevations (i.e. base rate scores above 74) on Scales 1 (Schizoid), 2 (Avoidant), 3 (Dependent), and 8 (Passive-Aggressive) with these four scales being the highest

among the eight basic personality scales (the 1-2-3-8 codetype). These clinical findings, when considered in light of the findings of Piersma (1986a), point to scales 1,2,3, and 8 as a possible measure of "initial distress" in certain psychiatric inpatients. What remains to be determined is a useful description of both the patients obtaining the 1-2-3-8 profile and the nature of distress these patients appear to be in.

The purpose of the present investigation is to examine the prevalence of this profile pattern among psychiatric inpatients. In addition, the general demographic characteristics and principle psychiatric diagnoses of these patients will be examined along with the configurations of the three severe personality disorder scales and nine clinical syndrome scales for the codetype. Finally, testable hypotheses will be explored as to why the 1-2-3-8 MCMI codetype appears to be a frequently occurring personality profile in inpatient populations and what utility the further empirical examination of these hypotheses might have for determining the diagnosis, treatment, prognosis, and discharge plans for such patients.

Method

Subjects and Procedure

Subjects were obtained from a pool of consecutive admissions to an acute inpatient psychiatric unit of a large northeastern general hospital who were referred for psychological testing from

1984 to 1987. Patients referred for organic impairment screenings or whose primary diagnosis was a substance abuse disorder were excluded from the subject pool. The MCMI profiles for 131 psychiatric inpatients were subjected to analysis to identify 1-2-3-8 profiles. Criteria for identifying the codetype were such that the configuration of the eight basic personality scales was of primary importance. Only profiles in which scales 1,2,3, and 8 were the four highest scales were considered. Of the 131 original profiles, 35 (26.72%) met the selection criteria. Thus, data were obtained on 35 predominantly white patients who fit the 1-2-3-8 codetype.

There were 19 males and 16 females comprising the sample. The clinical records, which included the patient's primary DSM-III diagnosis, were examined by the authors. Diagnoses were made by a series of two initial interviews; the first by a trained mental health professional, the second by a staff psychiatrist or psychiatry resident. All interviews were part of the standard admission procedures of the hospital and interviewers were familiar with DSM-III criteria.

Insert Table 1 and Figure 1 about here

Results

The means for each of the 20 MCMI scales are given in Table

1 and a mean 1-2-3-8 profile is presented in Figure 1 for the 35 inpatients. As expected, there are clinically significant elevations on scales 1,2,3, and 8. There are also prominent elevations on scales C (Borderline), A (Anxiety), H (Somatoform), D (Dysthymia), and CC (Psychotic Depression). A mean SUM 1-8 factor of 140.51 (SD = 11.26) was obtained which reflects a weight factor of -4 that is indicative of mild complaint tendencies in the sample. Because of the primarily depressive and borderline pathology that is apparent in the mean profile, case records were examined to determine the diagnoses and suicidal histories of the subjects. Table 2 provides the associated DSM-III diagnoses and the documented suicidal behavior of the patients. Percentages were based only on the number of subjects for whom clinical records were available (n=27); the medical records for some patients (n=8) were either incomplete or could not be obtained due to administrative difficulties.

Insert Table 2 about here

Discussion

As the diagnoses of the patients obtaining the 1-2-3-8 profile show, a significant proportion (59%) were hospitalized for treatment of an affective or related disorder. Moreover, it might be suggested that this profile pattern reflects a

depressive affective diosorder as evidenced by an analysis of the 12 individuals receiving a diagnosis of pure affective disorder. Of these patients, 10 received a diagnosis of major depression/ dysthymic disorder while 2 received a diagnosis of bipolar/ cyclothymic disorder. It may be that those patients with bipolar disorders completed the MCMI during a depressive phase of the disorder, thus accounting for the obtained 1-2-3-8 profile type. These observations are supported further when one looks at the elevations on the clinical scales of the mean 1-2-3-8 profile.

The significant elevations on scale D (Dysthymic), which corresponds to dysthymic disorders, and scale CC, which reflects a major depression (Millon, 1983), suggest that patients with the 1-2-3-8 codetype report that they experience prolonged periods of depressed or sad mood, accompanied by social withdrawl, pessimism toward the future, insomnia, early morning awakening, and other symptoms of depression. Support for these relationships was also obtained by McMahon and Davidson (1985) who found statistically significant positive correlations between MCMI scales 1,2,3, and 8 and measures of depression, fatigue, and tension and anxiety on the Profile of Mood States. Conversely, correlations between these clinical mood states and scales 4,5,6, and 7 of the MCMI were in the negative direction. Thus, while patients with the 1-2-3-8 codetype present the symptomatology associated with major depression, they may also complain of tension, restlessness, and

periods of fatigue, weakness, and vague bodily concerns. This fact is reflected in the findings of McMahon and Davidson (1985) as well as the significant elevations on MCMI clinical scales A (Anxiety) and H (Somatoform) in Figure 1.

To this point, one cannot overlook the fact that about 40% of the patients did not receive a diagnosis reflecting some affective/depressive disorder. This prompted an examination of the clinical records to evaluate clinical characteristics presented by the 1-2-3-8 patients diagnosed as schizophrenic or severe personality disorders (e.g. mixed, borderline). The most prominent clinical feature among patients was the documentation of suicidal ideation/rumination prior to admission. While suicidal ideation or attempts do not necessarily reflect depressed affect, it may be indicative of a general hopelessness in patients with 1-2-3-8 codetypes.

The personality style associated with this codetype appears to be a blend of schizoid, avoidant, dependent, and passive-aggressive traits. Such a style might reflect an individual with strong needs for dependency (scales 3 & C). The clinical picture would reveal several attempts at trying to get needs met and the person finding that others have failed to recognize these needs, resulting in emotional pain (scales A, D, & CC) and social withdrawl (scale 1). Moreover, the person develops an avoidant hypersensitivity to rejection and an expectation of further hurt

from significant others (scale 2). This causes feelings of anger that are expressed indirectly through passive-aggressive ways (scale 8) so as not to allow a direct expression of anger that may drive away those on whom the person depends. In some individuals, the anger may be turned against the self in the form of suicidal attempts or rumination which is of sufficient intensity to warrant hospitalization. Moreover, it can be hypothesized that with the significant elevations on the borderline scale and large percentage of suicide attempts among the sample, this profile may be reflective of a borderline personality structure (Chatham, 1985).

The fact that one out every four psychiatric inpatients from this sample obtained the 1-2-3-8 codetype suggests that the MCMI is sensitive to the identification of similar clinical characteristics in this population. Clearly this makes the importance of identifying the characteristics and clinical features of this codetype all the more pressing if the clinical utility of the MCMI is to be established. Though the present study has several methodological shortcomings, including incomplete clinical data and small sample size, it does raise some important questions for further investigation. More specifically: a) does the 1-2-3-8 codetype identify "initial distress" in the acute psychiatric inpatient; b) is the codetype predictive of suicidal thought/attempts; c) does the 1-2-3-8

profile identify affective disorder, specifically depression; and d) might this profile be indicative of a borderline personality structure.

Additionally, the fact that a large number of patients with schizophrenia obtained this codetype needs to be addressed in further research. The small sample size and profile averaging may have "averaged out" meaningful differences on the MCMI severe personality disorder scales and clinical scales. Therefore, a larger number of "depressed" and "schizophrenic" 1-2-3-8 profiles should be compared to determine the MCMI's ability to assist in making differential diagnoses. Finally, given the hypothesized dependent personality style of this codetype, the relationship between the 1-2-3-8 codetype and interpersonal problems should be explored. This will allow for greater insight into the need for integrating social support networks in the discharge plans of these psychiatric inpatients.

Overall, it is hoped that the present analysis and discussion of this MCMI codetype will encourage the further investigation of other commonly occurring codetypes not only in psychiatric inpatients, but in other clinical populations as well. Such an approach will increase the range of clinical applications for the MCMI and will also strengthen the body of empirical literature and interpretive data that supports the utility of this valuable assessment device.

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Table 1

Means and Standard Deviations for the MCMI Scales in the 1-2-3-8 Codetype

MCMI Scale	M	SD
1. Schizoid	87.77	12.77
2. Avoidant	97.37	12.02
3. Dependent	97.66	12.16
4. Histrionic	35.69	22.39
5. Narcissistic	29.71	20.67
6. Antisocial	30.83	22.29
7. Compulsive	46.80	17.06
8. Passive-Aggressive	91.83	10.71
S. Schizotypal	73.77	14.83
C. Borderline	81.63	13.18
P. Paranoid	54.89	17.63
A. Anxiety	99.14	10.94
H. Somatoform	78.94	15.19
N. Hypomanic	51.51	24.38
D. Dysthymic	94.23	12.70
B. Alcohol Abuse	70.83	13.48

Table 1 (cont'd)

Means and Standard Deviations for the MCMI Scales in the 1-2-3-8 Codetype

	MCMI Scale	M	SD
T.	Drug Abuse	56.51	20.68
SS.	Psychotic Thinking	72.43	11.89
CC.	Psychotic Depression	75.17	11.88
PP.	Psychotic Delusion	61.69	15.64

Table 2

Clinical Characteristics of the 1-2-3-8 MCMI Codetype

Clinical Characteristic	n	(%)
Principle Diagnosis (n=27)		
Affective Disorder	12	44
Schizophrenic Disorder	6	22
Schizoaffective Disorder	3	11
Severe Personality Disorder	5	19
Adjustment Disorder with Depressed Mood	1	4
	27	100
No diagnosis available	8	
Suicidal History (n=20)		
Previous Attempt	13	65
Ideation/Rumination	17	85
No suicidal history available	15	

Figure Captions

Figure 1. Mean 1-2-3-8 Profile (*n*=35)